FOCUS on Health Reform

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Establishing Health Insurance Exchanges: An Update on State Efforts

State-based health insurance exchanges are a key component of the Patient Protection and Affordable Care Act (ACA) of 2010, facilitating expanded access to coverage for millions of individuals and employees of small businesses. The health insurance exchanges, scheduled to be operational by January 2014, are intended to enable consumers to readily compare qualified health insurance options in order to select plans that best meet their needs. They will also be the mechanism through which low and moderate-income individuals receive premium and cost-sharing subsidies to make health coverage more affordable. The ACA allows states great latitude in how they design their exchanges, giving them flexibility over such things as how the exchange is structured, how it is governed, and how it certifies and contracts with health plans. If a state chooses not to create its own exchange, the federal government will operate one in the state. By 2019, the Congressional Budget Office estimates that over 24 million people will enroll in a health plan purchased through an exchange.[1]

In this issue brief, we review states' progress to date in creating health insurance exchanges. Some states have already taken major steps toward establishing an exchange, while other states have struggled to pass legislation or have opted not to begin the process of establishing one. By January 2013, the federal Department of Health and Human Services (HHS) will evaluate states to identify those that have not made sufficient progress toward establishing a "fully operational" state-based exchange.[2] This 2013 deadline poses a potential challenge for many states, particularly those that have not yet taken significant steps to establish an exchange. Now that most states' 2011 legislative sessions have concluded and the pace of legislative activity has abated, we have the opportunity to examine trends in states' initiatives to establish or study exchanges.

Status of State-based Exchanges

By July 2011, more than a third of states had begun laying the foundations for exchanges that meet the requirements outlined in the ACA. Table 1 depicts the current status of state activity related to creating exchanges.

Legislatures in 13 states passed laws to establish exchanges. Utah and Massachusetts had already created exchanges before 2011, though additional legislation may be required in both states to comply with ACA's specifications. Other states enacted legislation that did not go so far as to create an exchange, but allowed the state to continue moving forward with investigating whether or how to establish an exchange. North Dakota and Virginia both passed laws stating their intent to create an exchange and delegated responsibility for planning for the exchanges, including developing recommendations for the state legislature, to the state insurance and health and human services agencies. Mississippi and Wyoming decided to study the feasibility of creating an exchange.

Few additional states are expected to establish exchanges legislatively in the remainder of this year. Three states plus the District of Columbia have proposed legislation pending, though the 2011 legislative session in North Carolina will soon come to an end.

TABLE 1: STATE ACTION TOWARD CREATING EXCHANGES		
STATE	**STATUS OF LATEST STATE ACTION**	**PURPOSE OF STATE ACTION**
Alabama	Executive Order	Study feasibility of establishing an exchange
Alaska	Legislation failed	NA
Arizona	Legislation failed	NA
Arkansas	Legislation failed	NA
California	Enacted legislation	Establish an exchange
Colorado	Enacted legislation	Establish an exchange
Connecticut	Enacted legislation	Establish an exchange
Delaware	No proposed legislation	NA
District of Columbia	Pending legislation	NA
Florida	No proposed legislation	NA
Georgia	Executive Order	Study feasibility of establishing an exchange
Hawaii	Enacted legislation	Establish an exchange
Idaho	No proposed legislation	NA
Illinois	Enacted legislation	Intent to establish an exchange
Indiana	Executive Order	Intent to establish an exchange
Iowa	Legislation failed	NA
Kansas	No proposed legislation	NA
Kentucky	No proposed legislation	NA
Louisiana	Governor announced state will not have an exchange	NA
Maine	Legislation failed	NA
Maryland	Enacted legislation	Establish an exchange
Massachusetts	Existing Exchange	NA
Michigan	No proposed legislation	NA
Minnesota	Legislation failed	NA
Mississippi	Enacted legislation	Study feasibility of establishing an exchange
Missouri	Legislation failed	NA
Montana	Legislation failed	NA
Nebraska	Legislation failed	NA
Nevada	Enacted legislation	Establish an exchange
New Hampshire	Legislation failed	NA
New Jersey	Pending legislation	NA
New Mexico	Governor vetoed legislation	NA
New York	Legislation failed	NA
North Carolina	Pending legislation	NA
North Dakota	Enacted legislation	Intent to establish an exchange
Ohio	No proposed legislation	NA
Oklahoma	Legislation failed	NA
Oregon	Enacted legislation	Establish an exchange
Pennsylvania	Pending legislation	NA
Rhode Island	Legislation failed	NA
South Carolina	Legislation failed	NA
South Dakota	No proposed legislation	NA
Tennessee	No proposed legislation	NA
Texas	Legislation failed	NA
Utah	Existing Exchange	NA
Vermont	Enacted legislation	Establish an exchange
Virginia	Enacted legislation	Intent to establish an exchange
Washington	Enacted legislation	Establish an exchange
West Virginia	Enacted legislation	Establish an exchange
Wisconsin	No proposed legislation	NA
Wyoming	Enacted legislation	Study feasibility of establishing an exchange

As of July 19, 2011

There was no legislative activity around exchanges in 26 states, as of July 2011. Legislators in some states, such as New York and Rhode Island, debated proposed legislation to establish exchanges but were unable to come to consensus on key issues before the close of their legislative sessions. New Mexico passed legislation to establish an exchange, only to have the bill vetoed by the governor. Louisiana's governor announced early on that the state would not pursue creation of an exchange.

Although much attention has been focused on state legislative activity, legislation is not the only avenue toward establishing an exchange. The governors of Alabama, Georgia, and Indiana issued Executive Orders, announcing their states' interest in further study of a state exchange or, in the case of Indiana, the intent to conditionally establish an exchange without pursuing legislation. The governor of Kansas has not issued an executive order but instead placed study of a state exchange within the Insurance Commissioner's purview. With the 2013 deadline looming, governors in several other states are examining strategies other than legislation to maintain momentum toward establishing exchanges.

Trends in Exchange Design

Though states have a myriad of options when designing health insurance exchanges, there are some early trends in the preferred structure, governance strategy, and contracting type. For states that have begun to define the parameters of their exchanges, Table 2 highlights key decisions that have been made as of July 2011. More detailed descriptions of the progress made by five states is included in Appendix A.

Structure of Exchanges

The ACA gives states several options for how the exchanges can be structured. They can be established within an existing or new state agency, as an independent public entity, or as a non-profit. There are various considerations associated with each option.[3] Basing the exchange within an existing state agency enables the entity to efficiently leverage established administrative systems and procedures. An exchange that is a state agency is more closely tied to the government and accountable to elected officials. However, there may be value in maintaining independence and having the ability to define the administrative processes that best meet the needs of the exchange. Depending on the structure and governance, an exchange that is established as a quasi-governmental or non-profit entity may be more insulated from political influence and particular interest groups. However, a non-profit entity may find it challenging to perform functions that are typically viewed as governmental.

Most exchanges to date have been created with some independence from state government. In all, eight states chose a quasi-governmental structure and two others opted for a non-profit corporation. For example, Washington's exchange is "a public-private partnership separate and distinct from the state,"[4] while Maryland's exchange is a "public corporation and independent unit of state government."[5] Hawaii's legislature decided to establish the exchange as a non-profit corporation and the Indiana Executive Order indicates that the state's exchange, if created, would also be established as a non-profit corporation. In contrast, the exchanges in West Virginia, Vermont, and Utah are housed within the state governments, though all three have independent governing boards.

TABLE 2: KEY CHARACTERISTICS OF STATE EXCHANGES

STATE	STRUCTURE OF EXCHANGE	CONTRACTING TYPE OF EXCHANGE	SIZE OF GOVERNING BODY	STAKEHOLDER REPRESENTATION OR AREAS OF EXPERTISE OF APPOINTED BOARD MEMBERS
California	Quasi-governmental	Active purchaser	5	Various subject matter areas*
Colorado	Quasi-governmental	Clearinghouse	12	Various subject matter areas*
Connecticut	Quasi-governmental	Active purchaser	14	Health insurance coverage of individuals and small employers; health care finance; health benefit administration; health care delivery; health economist; heath care access for the self-employed; barriers to individual health coverage
Hawaii	Non-profit	Clearinghouse	15**	Insurance plans; provider group, hospital trade association; health care consumer; labor management; native Hawaiian health care organization; federally qualified health center; business; health information exchange**
Maryland	Quasi-governmental	To be decided by the Board of Directors	9	Employers and individuals using Exchange; various subject matter areas*
Massachusetts	Quasi-governmental	Active purchaser	11	Actuary; health economist; small business; employee health benefits plan specialist; health consumer organization; organized labor
Nevada	Quasi-governmental	Not addressed in legislation	10	Various subject matter areas*
Oregon	Quasi-governmental	Active purchaser	9	Various subject matter areas;* at least 2 small employer consumers of the exchange
Utah	Operated by State	Clearinghouse	up to 9	Insurance carriers; employee or employer; Office of Consumer Health Services; Public Employee's Health Benefits Program
Vermont	Operated by State	Active purchaser	5	Not specified in legislation
Washington	Quasi-governmental	To be decided by the Board of Directors	11	Employee benefit specialist; health economist or actuary; consumer advocate; small business; various subject matter areas*
West Virginia	Quasi-governmental	Not addressed in legislation	10	health care consumers; small employers; organized labor; insurance producers; payers; health care providers

* Members to possess some subject expertise, for example individual health care coverage, employer-sponsored health care coverage, health benefit plan administration, health care finance and economics, actuarial science, health care delivery system administration, purchasing and facilitating enrollment in health plan coverage, and public health.

** Description of Hawaii's Interim Board, which will be replaced on June 30, 2012. Ultimate Board of Directors will include eleven members appointed by Governor with advice and consent from Senate. Members of the Interim Board are eligible for the appointment to the Board

Exchange Governance

The recently released draft exchange regulation requires exchanges established as quasi-governmental and non-profit entities to have a clearly-defined governing board that is overseen by the state.[6] Some exchanges do not yet have a legislatively defined organizational structure. Of those that do, all of the exchanges are governed by independent Boards of Directors. These boards range in size from five to fifteen members, often representing both stakeholders and subject matter experts in an attempt to balance the political interests and management skills needed to operate an exchange.[7] Common subject matter experts include health economists, health actuaries, and people with experience purchasing or managing health benefits. Exchanges that require stakeholder representation on the board may specify the number of representatives of individual consumers or small employers, organized labor, health care providers, and/or insurance producers. Some states without stakeholder representation on the board have included a provision in the legislation requiring the board to create advisory groups to facilitate feedback.

Governors are often responsible for appointing the voting members of exchange boards, though many states allow other parties, such as legislators or stakeholder groups, to nominate or appoint some members. Ex officio members are frequently included on the boards of exchanges, particularly when the exchanges are quasi-governmental entities or non-profit corporations. In some cases, the ex officio members are non-voting participants.

Contracting Relationship with Qualified Health Plans

One of the more important functions of the exchange is its role in contracting with health plans. The ACA indicates that only plans meeting the standards of a qualified health plan (QHP) may participate in an exchange. A key question for state exchanges is whether they will contract with all QHPs, commonly referred to as the clearinghouse model, or whether they will selectively contract with only some QHPs, possibly to achieve stated goals around plan choice, quality, or value. This latter approach is referred to as the active purchaser model.

Of the 12 states with established exchanges, including Massachusetts and Utah, exchanges in five states will act as active purchasers while three others will serve as clearinghouses. Legislation in four states either did not address the issue or charged the board of the exchange with making the decision. Colorado's exchange will be a clearinghouse that "foster[s] a competitive marketplace for insurance and shall not solicit bids or engage in the active purchasing of insurance. All carriers authorized to conduct business in this state may be eligible to participate in the Exchange."[8] At the other extreme, California's board will selectively contract for health coverage offered through the exchange, "to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service."[9] In between these extremes are states like Oregon, where the exchange is permitted but not required to selectively contract with plans.

There are many ways in which an exchange can act as an active purchaser.[10] Even with a clear mandate to behave as an active purchaser, exchange boards must still more clearly define the exchange's role in relation to QHPs. The board may choose, for example, to require plan certification criteria beyond what is defined in the ACA or may negotiate with plans for better pricing or different product offerings. Boards can also use selective contracting to improve plan quality or can encourage plans to implement strategies to better coordinate health care services.

Conflict of Interest

Nearly all states included conflict of interest provisions for board members in the legislation that establishes the exchanges, though some are more restrictive than others. The boards are responsible for planning and operating the exchanges, as well as implementing the certification process to identify QHPs that may participate in the exchanges. Conflict of interest provisions are important when entities that might financially benefit from contracting with an exchange are represented on the board and may gain unfair advantage over competitors.[11] These provisions are even more important when the board is expected to behave as an active purchaser and negotiate with plans.

Legislation in some states, such as Hawaii and Washington, include provisions restricting appointees that have financial interest in matters addressed by the boards. A number of states' laws restrict the appointees to those who do not have a current relationship or affiliation with a health insurance carrier or limit the number of members with such affiliations. For example, the Colorado exchange requires that a majority of voting members not be directly affiliated with the insurance industry. A similar provision in the proposed exchange regulation seeks to ensure that boards represent consumer interests by requiring a majority of voting members not to have conflicts of interest, specifically mentioning representatives of health insurers, agents, brokers, or other individuals licensed to sell health insurance.[12]

The conflict of interest provisions are among the most restrictive in Maryland, California, and Connecticut, where the exchange boards are meant to act as active purchasers. In these states, board members cannot have relationships with a variety of players in the health care sector, such as carriers, insurance producers, third-party administrators, managed care organizations, health care providers, facilities or clinics, and/or entities contracting with the exchange.

Exchange Financing

Though the ACA requires all exchanges to be financially self-sufficient by January 1, 2015, few legislatures described the manner in which the exchanges can or should collect money. Nearly all exchanges were authorized to apply for public and/or private grants, though this funding may be most helpful during the planning and implementation stages. A few legislatures specified that the exchanges should collect assessments or fees from health plans, either restricted to plans participating in the exchange or applied broadly to all plans operating in the state. For example, Maryland's exchange is authorized to collect fees from plans within the exchange, but not to the extent that the fees create a competitive disadvantage with plans offered outside the exchange. Connecticut's exchange is authorized to collect charges from all plans capable of offering a qualified plan in the exchange. Oregon's financial provision is the most specific, basing the fee on the number of individuals enrolled in health plans offered through the exchange, excluding enrollees in state programs. The charge is limited such that it does not exceed 5% of premiums for each enrollee through the exchange where the total enrollment is no more than 175,000, 4% of premiums for between 175,000 and 300,000 enrollees, or 3% of premiums for more than 300,000 enrollees.

Next Steps in Exchange Implementation

For most states with established exchanges, the first stage after enacting legislation is to nominate board members and hire staff. So far, only a small number of exchanges have hired staff or appointed boards. The board of California's exchange, only recently completed, includes four appointed members with in-depth knowledge of California state and local government and health care policy, plus one representative of an employer. The board of Maryland's exchange, with five of six appointed members, includes a large diversity of experience such as an economics professor, a consumer advocate, and a representative of employers. Colorado's nine-member exchange board, the latest to be completed, includes four executives of managed care or insurance companies, one executive of a health technology company, one physician, and one consumer advocate.

Once the boards are in place, many exchanges will also establish advisory groups. Maryland has created four advisory groups with up to 17 members and different focus areas: operating model and insurance rules; the Navigator and enrollment; the SHOP; and financial sustainability. Washington's exchange legislation requires an advisory group to represent the views of the health care industry and other stakeholders, and allows for the establishment of technical advisory committees if needed. Most states' laws authorize, but don't require, advisory groups.

Within the first few meetings, exchange boards may also need to create the bylaws and policies that will guide the exchanges, including defining reporting requirements, hiring processes, and procurement policies. Putting these policies in place is particularly important for non-profit or quasi-governmental exchanges to enable them to perform basic functions, such as hiring staff and awarding contracts. Boards may also take this time to identify vendors and subcontractors to facilitate collection of stakeholder feedback and complete policy analyses.

Many states require exchange boards to report to state legislatures on a regular basis, with initial reports due, in most cases, around January 2012. These reports are the next step toward addressing the critical policy questions that must be answered before the exchanges can be fully operational, such as the structure of the SHOP exchange, the nature and degree of coordination between the exchanges and public programs, and strategies to avoid adverse selection. During the 2012 legislative session, many states' General Assemblies will evaluate the recommendations proposed by the boards and, if necessary, vote on legislation better defining the structure and function of the exchanges. Many state legislatures also plan to create joint, bipartisan standing committees focused on health reform to better evaluate the exchanges' progress and assist the exchange boards with implementation.

Federal Funding for Exchanges

To date, the federal government has distributed $326 million to states seeking to establish health insurance exchanges. Figure 1 displays the type of federal grant funding each state has received to assist in planning and establishing insurance exchanges.

Exchange Planning Grants

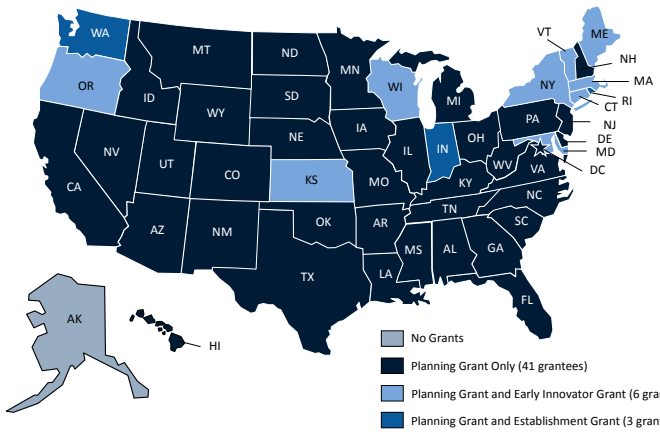
All states, except Alaska, received an Exchange Planning Grant of between $800,000 and $1 million, though Florida has since announced it plans to return this funding. This planning grant was intended to give states the resources necessary to investigate and research the options to create state-based health insurance exchanges.

Early Innovator Grants

HHS created a second funding opportunity designed to support a small number of states with building the information technology (IT) infrastructure for exchanges. These Early Innovator Grants were distributed to six states (though Oklahoma has indicated it will return the grant funds to HHS) and one consortium, consisting of five New England states, to tackle the thorny issue of creating a consumer-friendly IT infrastructure for the exchanges. These grants range from $6 million for Maryland to $48 million for Oregon. To receive this funding, grantees demonstrated that they had begun planning their exchanges and possessed the technical expertise and ability to develop IT systems. These states will investigate IT options that are transferable and reusable, enabling other states to use parts or all of the systems they create.

Figure 1

Federal Health Insurance Exchange Grants, July 2011



NOTES: Oklahoma has indicated it will return the Early Innovator Grant funding. The grant awarded to the University of Massachusetts Medical School is for a multi-state consortia which includes Connecticut, Maine, Massachusetts, Rhode Island, and Vermont.

Exchange Establishment Grants

In January 2011, HHS announced the availability of Exchange Establishment Grants. Each quarter through June 2012, states have the opportunity to apply for a Level One Grant, which provides up to one year of funding to states that have made some progress in establishing an exchange. Although the grant funds can be used for a number of different planning activities, it is expected that much of this funding will be directed toward developing an IT system for the exchange.

Thus far, three states have applied for and received Level One Establishment Grants. Washington's exchange, established legislatively in May 2011, received $23 million to investigate eligibility, enrollment, and IT systems. Indiana received $7 million to continue planning for their exchange. Rhode Island received $5 million to study exchange options, despite the legislature's inability to pass legislation enacting the exchange in 2011.

States may also apply for Level Two Establishment Grants, which are designed to provide funding through December 31, 2014. In order to be eligible for this grant, states must demonstrate the legal authority to establish and operate the exchange, among other criteria.[13] Demonstration of legal authority could be legislation or another general authority (such as an Executive Order) with a written legal opinion certifying that the state is authorized to establish the exchange under state law.[14] States that received Level One funding, but do not yet qualify for multi-year Level Two funding, can reapply for another Level One Grant.

Future Prospects for State Exchanges

While some states are moving quickly to establish and implement exchanges, others are moving much more cautiously. The reasons for the slow pace in many states are numerous, but a critical issue is the uncertainty that continues to surround the ACA in general and the exchange provisions in particular. More than 20 legal challenges are currently wending their way through the courts, many filed by state governors and attorneys general.[15] Some states may be reticent to take any concrete steps toward creating an exchange until the results of the lawsuits are clearer. In addition, until the proposed exchange regulation was released recently, many states claimed they lacked the guidance from HHS to make the critical decisions necessary to establish their exchanges. While the proposed rule may offer some clarity for states, most legislative sessions have ended, meaning any significant legislative action will have to wait until next year.

The 2013 deadline for having an operational exchange is fast approaching, and even those states moving more aggressively may find it difficult to put all the pieces into place in time to meet it. Recognizing this challenge, HHS offered several strategies in its proposed rule to promote the formation of state-based exchanges.[16] One option is described as a flexible partnership model, which would allow for combined state and federal business functions, such as eligibility and enrollment, financial management, and health plan management systems and services. HHS will also grant conditional approval for state exchanges that may not be able to demonstrate complete readiness on January 1, 2013, but that are expected to be operational by January 2014. Finally, states not ready to run their own exchanges beginning in 2014 may transition from a federal exchange to a state exchange when they have the capability, though they must receive approval for their exchange at least 12 months prior to the start of coverage.

The work ahead for states seeking to create operational exchanges by 2014 is significant. Those states that have already established exchanges have an advantage and can begin the process of staffing and defining administrative and operational processes immediately. These states can also begin tackling more challenging issues such as building an IT infrastructure to support exchange functions. But even states that have not yet established exchanges can begin or continue the planning process to work toward answering foundational issues related to the structure and governance of an exchange. There is no single path toward establishing state-based exchanges, as evidenced by the myriad of approaches states have taken to date. For those states interested in running their own exchanges, these next few years provide a unique opportunity to plan a health insurance exchange tailored to the needs of their state with the support of federal funding.

Appendix A: Case Studies of Selected States Establishing Health Insurance Exchanges

The following are brief descriptions of developments in a handful of states that are working toward implementing state-based exchanges. The states profiled have adopted different approaches for moving forward with creating their exchanges and are in different stages in the implementation process.

California

On September 30, 2010, Governor Schwarzenegger signed two complementary bills, AB1602 and SB900, to establish the California Health Benefit Exchange as a quasi-governmental organization that will selectively contract with qualified health plans (QHPs).[17] California was the first state in the nation to pass legislation creating a health insurance exchange after the enactment of federal health reform.

The Exchange is governed by a five-member board, including the Secretary of California Health and Human Services (or designee) as a voting, ex officio member. Additional board members include Kimberly Belshé (Public Policy Institute of California), Paul Fearer (Union Bank and Pacific Business Group on Health), Susan Kennedy (former Chief of Staff for Governor Schwarzenegger), and Dr. Robert Ross (The California Endowment).

The Board meets at least monthly throughout 2011. In these meetings, the Board continues to focus on hiring staff, collecting stakeholder input, investigating coordination of programs (e.g., Medi-Cal, Healthy Families), defining options for the creation of the small employer exchange, and identifying an information technology (IT) system. In addition, the Board will more clearly define the Exchange's role as an active purchaser, such as clarifying the minimum requirements that carriers must meet to be considered for participation in the Exchange. California, unlike some other states, has experience acting as an active purchaser through other programs, such as the Children's Health Insurance Program, small-business purchasing pool, and state employee purchasing pool.

California received a federal Exchange Planning Grant of $1 million and applied for a federal Level One Establishment Grant. If the latter is awarded, these funds will be used to create an overall business and operational plan, conduct research and analysis, and implement an IT system. The Board also plans to submit an application for the Level Two Establishment Grant by September 2011. In addition to the federal grants, the legislation creates the California Health Trust Fund within the state treasury, which will be used to manage the finances of the Exchange. The legislation authorizes a loan of up to $5 million from the California Health Facilities Financing Authority. The California HealthCare Foundation and the Blue Shield of California Foundation have also funded activities in preparation for applying for the federal Establishment Grant.[18]

Colorado

On June 1, 2011, Governor Hickenlooper signed SB11-200 into law, establishing the Colorado Health Benefit Exchange as a quasi-governmental organization that will serve as a clearinghouse for QHPs.[19] The Exchange is governed by a 12-member board, including three ex officio, non-voting members (or their designees): the Executive Director of the Department of Health Care Policy and Financing, the Insurance Commissioner, and the Director of the Office of Economic Development and International Trade. The current voting members include Richard Betts (ASAP Accounting & Payroll, Inc.), Robert Ruiz-Moss (Anthem Blue Cross), Eric Grossman (TriZetto), Elizabeth Soberg (UnitedHealthcare of Colorado), Gretchen Hammer (Colorado Coalition for the Medically Underserved), Nathan Wilkes (Headstorms, Inc.), Dr. Michael Fallon (emergency-room physician), Stephen ErkenBrack (Rocky Mountain Health Plans), and Arnold Salazar (Colorado Health Partnerships). At the first Board meeting, which took place on July 11, consumer advocates voiced concerns that a majority of the Board has close affiliations with the insurance industry, which would be a violation of the legislation establishing the Exchange.

By January 15, 2012, the Board is required to submit a report of the Exchange's planning and establishment activities to the Governor, the Senate Health and Human Services Committee, and the House Health and Environment Committee. Key issues in the report include: appropriate size of the small employer market in the Exchange; unique needs of rural residents of Colorado, and the Exchange's initial operational and financial plan. To assist with planning and research, the state has contracted with the Colorado Health Institute (CHI).[21] The CHI created advisory groups and facilitated meetings focused on specific topics: data systems; eligibility, verification, and enrollment; marketing, education, and outreach; and small employers. These advisory groups began meeting months before the exchange legislation passed and will continue to meet throughout the summer of 2011.

The Board does not have the authority to promulgate rules. Instead, the legislation creating the Exchange also established the joint, bipartisan Legislative Health Benefit Exchange Implementation Review Committee to report up to five bills or other measures each year to the Legislative Council related to planning and establishing the exchange. The Committee is also charged with reviewing the financial and operational plans of the exchange and grant applications.

Indiana

On January 14, 2011, Governor Daniels signed an Executive Order to conditionally establish and operate the Indiana Insurance Market, Inc., a non-profit corporation to serve as the Indiana health benefit exchange.[22] The state later commissioned a legal analysis which concluded that legislation is not required to establish an exchange as a non-profit but may be necessary for Indiana to move forward with full exchange implementation.[23]

Indiana is among the first three states to be awarded a federal Level One Exchange Establishment Grant of $6.9 million to update their information technology systems and provide project management; legal, actuarial, and financial expertise; and general policy support to assist with implementing the exchange. Indiana also received a federal Exchange Planning Grant of $1 million in September 2010.

Indiana has engaged subcontractors to assist in researching the state's health care market and potential users of the Exchange. The state also continues to collect stakeholder insight through questionnaires and meetings and to establish collaborative partnerships. Information collected in this next phase of planning will be used to define the legal structure, governance, and operations of the Exchange. The state anticipates addressing long-term financing after completing the design of the Exchange. In the meantime, the Governor's office continues to work with the Indiana Family and Social Services Administration and Department of Insurance to assess existing IT resources and to investigate strategies for integrating the Exchange with existing programs.[24]

Maryland

On April 12, 2011, Governor O'Malley signed SB182/HB166 into law establishing the Maryland Health Benefit Exchange as a quasi-governmental organization.[25]

The Exchange is governed by a nine-member Board. The Board includes three ex officio members (or their designees): the Executive Director of Maryland's Health Care Commission, the Secretary of Health and Mental Hygiene, and the Commissioner of Insurance. Five of the six remaining members have been appointed: Professor Darrell Gaskin (Johns Hopkins University), Dr. Georges Benjamin (American Public Health Association), Jennifer Goldberg (Maryland Legal Aid Bureau), Enrique Martinez-Vidal (AcademyHealth and Robert Wood Johnson Foundation), and Thomas Saquella (Maryland Retailers Association).

The legislation requires the Board to study outstanding implementation issues and submit recommendations to the Governor and General Assembly by December 23, 2011. Key questions include: whether and how the Exchange will engage in selective contracting, the potential for multistate or regional contracting, the creation of the Exchange's IT framework, and the design and approach to the SHOP Exchange. The legislation does specify that small employers with 51 to 100 employees will qualify for the SHOP by January 1, 2016.

In addition to preparing recommendations for the legislature, the Exchange Board will continue hiring staff, coordinating with advisory committees, and applying for federal grant funding. The exchange board submitted an application for a Level One Establishment Grant in late June. Maryland already received two federal grants: the Exchange Planning Grant of $1 million and the Early Innovator Grant of $6.2 million to establish a technology foundation for the Exchange. The Board will be able to access additional funding once the Exchange is operational, in the form of fees collected from plans within the Exchange. The legislation specifies that the fees should be set so as to avoid creating a competitive disadvantage with plans offered outside the Exchange.

Virginia

On April 6, 2011, Governor McDonnell signed HB2434 into law, declaring the state's intent to establish a health insurance exchange.[26] The legislation was based on a recommendation by the Virginia Health Reform Initiative (VHRI) Advisory Council, housed within the Virginia Department of Health and Human Resources and funded, in part, by the Virginia Health Care Foundation and the Robert Wood Johnson Foundation.[27]

The legislation requires the Governor, through the Secretary of Health and Human Resources and with the State Corporation Commission's Bureau of Insurance, to submit recommendations regarding establishment of the Virginia Exchange for consideration by the 2012 legislative session. The recommendations should address specific topics, including: exchange structure; make-up of the governing board; resources required; and potential impact of the exchange on the insurance markets and health programs. The legislation also prohibits qualified health insurance plans offered through the exchange from covering abortions, except when the pregnancy endangers the mother's life or the pregnancy is the result of rape or incest.

To inform these recommendations, the VHRI Advisory Council and related Task Force members are completing background analyses and collecting stakeholder feedback. In April 2011, the VHRI sought written feedback in response to a background memorandum focused on governance and convened a follow-up meeting the following month to collect oral feedback on the same topic.[28] Based on this meeting, the VHRI Advisory Council concluded that 11 to 15 board members will be appointed by the Governor and General Assembly.[29] Opinions about the structure of the Exchange were mixed, though a majority of the Council preferred a quasi-public agency. The VHRI Advisory Council scheduled additional meetings to discuss establishment of the Virginia Exchange, beginning with strategies to promote competition.[30]

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